

combine reference teachings. Second, there must be a reasonable expectation of success. Finally, the prior art reference (or references when combined) must teach or suggest all the claim limitations. (See M.P.E.P. Section 2143).

No Motivation to Combine

In the present case, at least two of these criteria are lacking the Office Action. First, there is no suggestion or motivation, either in the references themselves or in the knowledge generally available to one of ordinary skill in the art, to modify Davis et al. or combine it with Brown.

The present invention, as defined in claims 1 and 12, is drawn to a specific network architecture that provides advantages over the prior art. As illustrated below, the invention requires: "a wireless communication device connected to a first wireless network"...which can send and receive "communications over the Internet" (see A, below) and "a second network" connected to "the Internet and first wireless network" (see B and C, below).

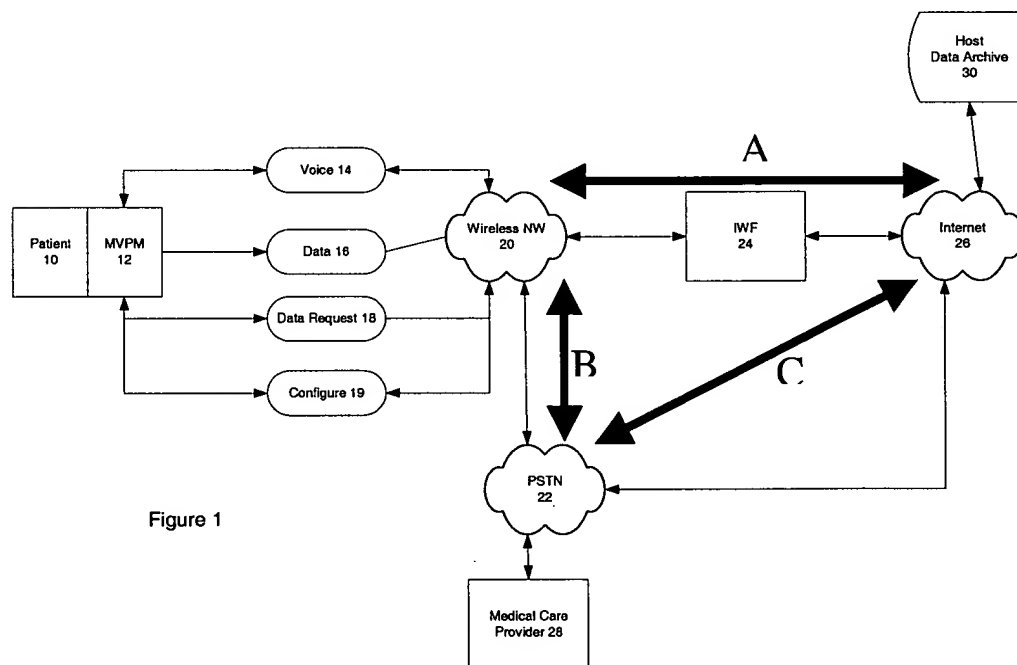
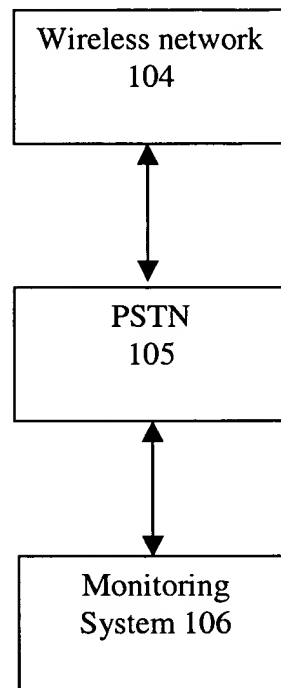
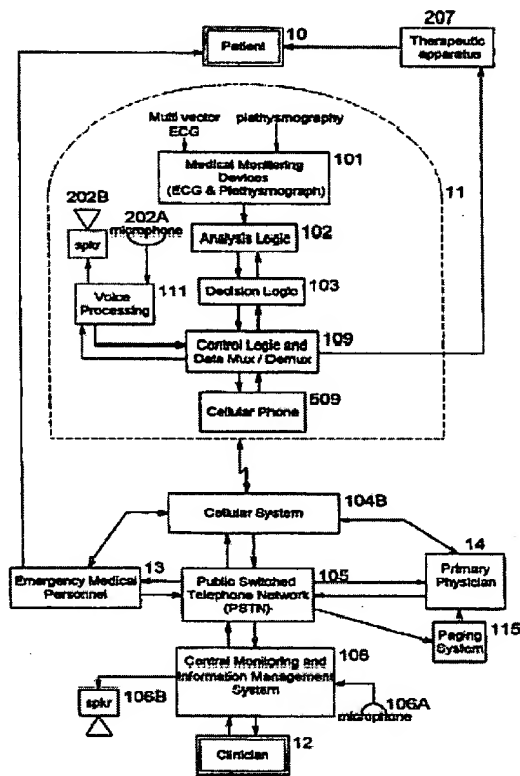


Figure 1

With the patient monitor, Host archive and medical care provider at each "corner," the presently claimed invention has a triangular network architecture.

However, neither Davis et al. nor Brown teach or fairly suggest such a network architecture. As illustrated in figure 1 of Davis et al., the network architecture is essentially linear:



In a like manner, Brown is also drawn to an essentially linear architecture, as illustrated in figure 2, wherein all communication passes through server 18:

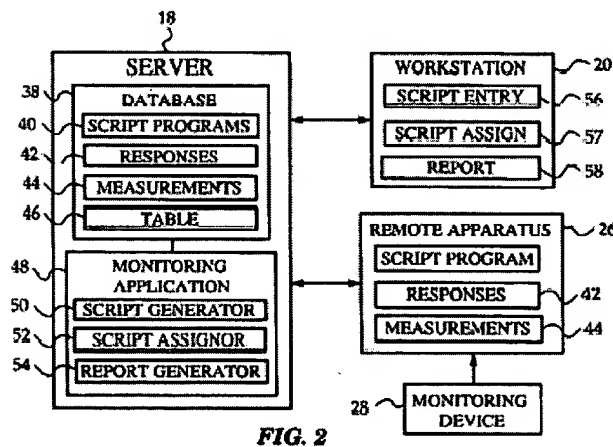
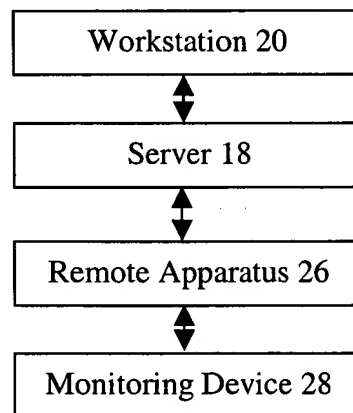


FIG. 2

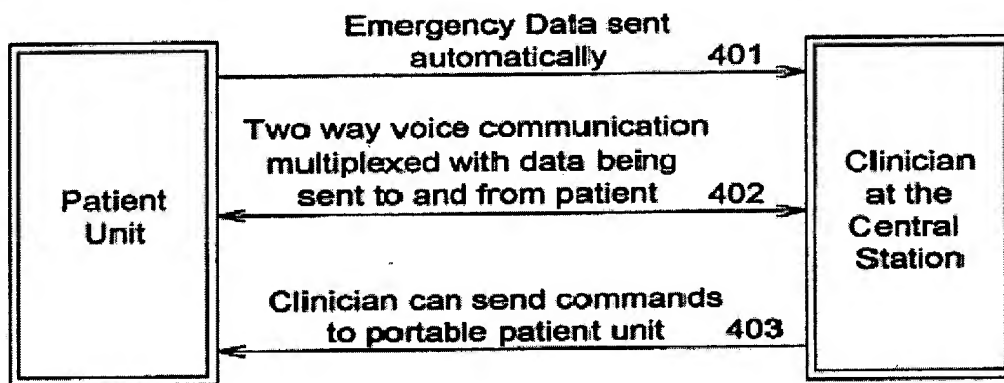


One advantage of the triangular network architecture is found on page 8, lines 7-12, where the bi-directional voice communication between the medical care provider and the patient is discussed:

"In the event that voice traffic is being transmitted from the patient, a cellular network 20 connects to the public telephone network 22 to communicate with the medical care provider (or 911 operator). Although network 22 will usually be a PSTN, other non-switched connections, such as ISDN, DSL, satellite, and cable modem connections can also be used. Again, *in this fashion, the medical care provider can receive voice information from the patient 10 and provide voice feedback to the patient as well.*" (Emphasis added).

Davis et al. teaches the provision of bi-directional voice communication between the patient and clinician *at a central station* over a *single* network via multiplexing, such as at 402 of figure 4.

Fig. 4



However, the central station model of Davis et al. has significant drawbacks. The central monitoring system adds an additional layer of abstraction (clinician) between the patient and physician (i.e., their medical care provider), whereas the present invention allows direct monitoring by the patient's medical care provider via the Internet access to the Host archive.

The separate Host data archive and medical care provider terminals of the present invention additionally allow multiple medical care providers to monitor the same patient. It also

releases the burden of data-logging from the medical care provider terminal such that data other than emergency data can be regularly transmitted without overloading the medical care provider terminal with data. The central monitoring model of Davis et al., on the other hand, limits data logging to emergency situations.

Brown fails remedy the omissions of Davis et al. since it fails to suggest any reason to alter the linear network architecture of Davis et al. to provide the claimed triangular network. Brown doesn't even suggest bi-directional voice communication, only voice-synthesis and recognition (see fig. 15). Like Davis et al., Brown adds additional layers of abstraction between the patient and the physician via "scripts" since: (i) there can be a significant time delay because scripts will only run when the remote device connects to the server (see column 9, lines 37-38), and (ii) the only information generated (in the form of patient reports) is the data that is requested via scripts.

Additionally, as Davis et al. is drawn to a self-contained monitor with automatic emergency reporting, it is unclear why including "*communication via the Internet, as taught by Brown...*" would result in data being "*collected in a less costly way*" since logging the continuous data necessary for monitoring for emergency situations to the Internet would vastly increase the communication costs if done with Davis et al.'s cell phone or would dramatically limit the mobility of Davis et al.'s patient if an Internet connection replaced the cell phone.

As for the additional stated motivation "*because then data...would be more accessible on a World Wide Web server,*" neither Davis et al. nor Brown suggest the desirability of wider patient data accessibility. Davis et al. has no need for patient data access beyond the clinician. Brown also fails to suggest any wider patient data accessibility, but rather only provides access to patient data by running scripts with a patient report request.

All Claim Limitations Not Shown

As discussed above, neither of the linear network architectures of Davis et al. and Brown, disclose a triangular network architecture between a patient-worn monitoring unit, a Host data archive and a medical care provider terminal.

In view of the above arguments, Applicant respectfully submits that claims 1-22 are novel and non-obvious over the cited prior art.

Conclusion

For the reasons cited above, Applicants submit that claims 1-22 are in condition for allowance and requests reconsideration of the application. If there remain any issues that may be disposed of via a telephonic interview, the Examiner is kindly invited to contact the undersigned at the local exchange given below.

Respectfully submitted,



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